

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUSSTATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

16332

State File No. 4477

Registrar's No.

MAY 27 1943

318

1003

Registration District No.

Primary Registration District No.

1. PLACE OF DEATH:

- (a) County.....
(b) City or town..... St. Louis,
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
0 Alexian Brothers Hospital
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution..... (Specify whether
In this community..... One Day
years, months or days)

3. (a) PRINT
FULL NAMEDr. LOUIS LITSCH Sr.

3. (b) If veteran,
-
- name war.....

3. (c) Social Security
-
- No.....

4. Sex Male 5. Color or White 6. (a) Single, widowed, married,
divorced Married
6. (b) Name of husband or wife..... Norma Litsch 6. (c) Age of husband or wife if
alive..... 53 years
7. Birth date of deceased April 1st 1885
(Month) (Day) (Year)

8. AGE: Years Months Days If less than one day
58 1 10 hr. min.

9. Birthplace St. Louis, Missouri
(City, town, or county) (State or foreign country)

10. Usual occupation..... Chiropractor
Own Business

11. Industry or business.....

12. Name..... Ignatius Litsch
13. Birthplace..... Unknown Germany
(City, town, or county) (State or foreign country)
14. Maiden name..... Victoria Huschle
15. Birthplace..... Unknown Germany
(City, town, or county) (State or foreign country)

16. (a) Informant.....
- Norma Litsch

- (b) Address.....
- 3347 California Ave.

17. (a) Burial (b) Date thereof May 14 1943
(Burial, cremation, or removal) (Month) (Day) (Year)

- (c) Place: burial or cremation.....
- New SS. Peter & Paul Cemetery

18. (a) Signature of funeral director.....
- Wm. J. Robert

- (b) Address.....
- 1905 South Grand Blvd.

19. (a) MAY 13 1943 J. F. Bredeck
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

- (a) State Missouri (b) County.....
(c) City or town..... St. Louis, Missouri
(If outside city or town limits, write "RURAL")
(d) Street No. 3347 California Ave.
(If rural, give location)
(e) Citizen of foreign country?..... (Yes or No)
If yes, name country..... 0

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month May day 11
year 1943 hour 12 minute 30 P. M.

21. I hereby certify that I attended the deceased from 4-1-43
....., 19....., to 5-11-43, 19.....
that I last saw him alive on 5-11-43, 19.....
and that death occurred on the date and hour stated above.

Immediate cause of death.....

Spontaneous pneumonia
Myocardial infarction
Acute Myocarditis

Due to.....
Due to.....

Other conditions..... Serotonin (left)
(Include pregnancy within 3 months of death)

Major findings:

Of operations.....

Of autopsy.....

22. If death was due to external causes, fill in the following:

- (a) Accident, suicide, or homicide (specify).....
(b) Date of occurrence.....
(c) Where did injury occur?..... (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?

While at work?.....

Signature..... John A. Smith M.D. (M. D. or other) MD.
2767 Grand Ave. Date signed 5-12-43

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....
....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

John Ketter

Licensed Embalmer No.....

3880

P. O. Address.....

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.